COUNTY OF SAN BERNARDINO
MENTAL HEALTH PLAN

Consolidated Implementation Plan
For
Inpatient and Outpatient
Specialty Mental Health Services

Revised December 14, 2005

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INTRODUCTION

A. Purpose of the Mental Health Plan (MHP) Implementation Plan

The purpose of the initial implementation plans for psychiatric inpatient hospital services and outpatient specialty mental health services, submitted in 1994 and 1998, respectively, was to describe the procedures to be followed in establishing the San Bernardino County Mental Health Plan (MHP), and in transitioning from a State administered Medi-Cal system to one coordinated by the County. These documents included a large amount of very detailed information, including descriptions of planning processes, stakeholder meetings, etc. Now that Phases I (inpatient) and II (outpatient) of the MHP have been in place for 11 and 7 years, respectively, a significant number of operational procedures have changed. It seems appropriate, therefore, to revise the Implementation Plan with a view to:

1. Making the Implementation Plan a useful guide to the mental health delivery system in San Bernardino County;
2. Providing a description of current operational procedures; and
3. Eliminating historical information about the planning for and early implementation of the MHP.

B. Foundation in Title 9 of the *California Code of Regulations*

The regulatory foundations of much of the Implementation Plan are contained in Title 9 of the *California Code of Regulations*. Rather than quoting the applicable sections of Title 9 in the Implementation Plan, however, we have attempted to paraphrase the regulatory language in a way which makes it more readily accessible to the average reader.

C. Plan of the Consolidated Implementation Plan

We have used the basic outline contained in Section 1810.310 of Title 9 for the Consolidated Implementation Plan. Under each heading, we describe separately the procedures for psychiatric inpatient hospital services and outpatient specialty mental health services. It is our hope that this consolidated version offers the convenience of a single body of source material, combined with ease in locating specific information regarding a particular type of mental health service.

AUTHORIZATION OF SPECIALTY MENTAL HEALTH SERVICES

A. Authorization Procedures for Psychiatric Inpatient Hospital Services

The "Inpatient Point of Authorization" is the function within the MHP which receives provider communications 24 hours per day, seven days per week, regarding requests for MHP payment authorization for psychiatric inpatient hospital, psychiatric health facility, and psychiatric nursing facilities services. The San Bernardino County MHP Inpatient Point of Authorization is physically located at:

San Bernardino County Department of Behavioral Health
Inpatient Authorization Unit
850 East Foothill Boulevard
Rialto, CA 92376

The Inpatient Point of Authorization's mailing address is:

San Bernardino County Department of Behavioral Health
Inpatient Authorization Unit
P. O. Box 2610
San Bernardino, CA 92406-2610

The Inpatient Point of Authorization's telephone number is:

(909) 421-9253

The Inpatient Point of Authorization's FAX number is:

(909) 873-4441

In order to be eligible to receive payment for psychiatric inpatient hospital services to a Medi-Cal beneficiary, all provider hospitals (except San Bernardino County's Arrowhead Regional Medical Center) must do the following:

1. Within 10 days of the patient's admission, submit a "24-Hour Notification" to the Point of Authorization.
2. Within 14 days of the patient's discharge, submit a Treatment Authorization Request (TAR) and a copy of the patient's complete and entire medical record to the Point of Authorization's physical or mailing address. **Patients' medical records should not be FAXed to the Point of Authorization.**

Inpatient Authorization Unit staff will review the medical record and the TAR. The following criteria must be met before payment may be considered:

1. The patient was eligible for San Bernardino County Medi-Cal during the hospital stay and had coverage which included psychiatric inpatient hospital services;
2. A 24-Hour Notification was submitted within 10 days of the patient's admission;

3. A correctly completed TAR was submitted within 14 days of the patient's discharge, together with a complete and entire medical record for that hospital stay;

4. Documentation for acute days has been found to meet medical necessity criteria (see additional information below);

5. Documentation for administrative days has been found to meet administrative day service criteria (see additional information below); and

6. All other applicable Title 9 requirements have been met.

The Point of Authorization will either approve or deny the TAR within 14 calendar days of the receipt of the TAR—unless it has been necessary to return the TAR and the medical record to the provider hospital for some reason (e.g., TAR filled out incorrectly, beneficiary has other health coverage, provider not in compliance with contractual agreement, or factual documentation missing). If the Point of Authorization determines that necessary factual documentation was not submitted with the TAR, it will notify the provider hospital, which will then have 60 calendars days in which to submit the requested material.

Provided below is additional information regarding medical necessity criteria for reimbursement of psychiatric inpatient hospital services.

Medical Necessity Criteria for Admission

1. The beneficiary must have a covered diagnosis from among the following:

    - Pervasive Developmental Disorders
    - Disruptive Behavior and Attention Deficit Disorders
    - Feeding and Eating Disorders of Infancy or Early Childhood
    - Tic Disorders
    - Elimination Disorders
    - Other Disorders of Infancy, Childhood or Adolescence
    - Cognitive Disorders (Only Dementias with Delusions, or Depressed Mood)
    - Substance Induced Disorders, Only with Psychotic, Mood or Anxiety Disorder
    - Schizophrenia and Other Psychotic Disorders
    - Mood Disorders
    - Anxiety Disorders
    - Somatoform Disorders
    - Dissociative Disorders
    - Eating Disorders
    - Intermittent Explosive Disorder

- Pyromania
- Adjustment Disorders
- Personality Disorders

The following diagnoses are NOT covered when they are the primary diagnoses given to the patient:

- Autism
- Mental Retardation
- Dementia Except with Delusions or Depressed Mood
- Learning Disorders
- Substance-Induced Disorders Except with Psychotic, Mood or Anxiety Disorder
- Mental Disorders Due to a General Medical Condition
- Sleep Disorders
- Sexual Dysfunction

2. In addition to having a covered diagnosis, the focus of the treatment plan and the documentation of the treatment provided to the patient must be consistent with the diagnosis.

3. The patient cannot be treated safely at a lower level of care. There should be documentation as to why the patient cannot be treated safely and effectively at a lower level of care.

4. The patient requires inpatient treatment because she/he is:

   a. <u>A Danger to Self</u>

      Charting should include documentation of general risk factors, including previous suicide attempts due to a mental disorder, as well as current risk factors, including serious threats, intent, a specific plan, or command hallucinations.

   b. <u>A Danger to Others</u>

      Charting should include documentation of general risk factors, including previous homicide attempts due to a mental disorder, as well as current risk factors, including serious threats, intent, a specific plan, or command hallucinations.

   c. <u>Poses a Risk of Significant Property Destruction</u>

      Charting should include documentation of general risk factors, including previous attempts at significant property destruction due to a mental disorder, as well as current risk factors, including serious threats, intent, a specific plan, or command hallucinations.

d. Is Gravely Disabled

Documentation should describe clearly which of the patient's behaviors require the need for the type of 24-hour supervision provided on the inpatient unit. It is important to remember that many patients, although unable to provide for their basic needs, are able to utilize food, clothing or shelter which is offered to them. Documentation should indicate why patients in this category could not be treated safely and effectively at a lower level of care.

e. Presents a Severe Risk to His/Her Physical Health

Documentation should include a description of the behavioral factors which pose a danger to the patient's health and which are the result of the patient's mental disorder, such as:

- Refusal to take life-sustaining medication;
- Grossly inappropriate use of prescribed medications resulting in serious threats to health;
- Engaging in high-risk behaviors.

f. Exhibits a Recent, Significant Deterioration in Ability to Function

Documentation should include:

- Description of the patient's previous level of functioning;
- Description of precipitating or aggravating events;
- Description of the resulting behavioral or emotional changes which resulted in deterioration;
- A statement as to why the patient could not be safely and effectively treated at a lower level of care.

g. Requires Further Psychiatric Evaluation

Documentation should include a statement of the diagnostic questions to be answered by the inpatient psychiatric evaluation, as well as reasons why the information needed to answer these questions could not be obtained at a lower level of care.

h. Requires Medication Treatment Which Can Only Be Provided in an Inpatient Setting

Documentation should include a clear statement as to why an inpatient level of care is required for medication adjustments or stabilization, as well as a description of past adverse reactions or emergency situations related to medication adjustments.

i. Requires Other Treatment Which Can Only Be Provided if Patient is Hospitalized

Continued Stay Criteria

In order to qualify for continued stay criteria, the patient must meet one of the following:

1. Continued presence of indications which meet medical necessity criteria as specified above;
2. Exhibits a serious adverse reaction to medications, procedures or therapies requiring continued inpatient treatment;
3. Presence of new indications which meet medical necessity criteria as specified above;
4. Need for continued medical evaluation or treatment which can only be provided in a psychiatric inpatient hospital.

Note: An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the discharge of the patient from the hospital.

Administrative Day Criteria

In order to qualify for administrative days, the following criteria must be met:

1. During the hospital stay, the patient had previously met medical necessity criteria for reimbursement of acute psychiatric inpatient services for at least one day.
2. There is no appropriate, non-acute treatment facility placement within a reasonable geographic area.
3. For adults, the following types of non-acute treatment facility placements meet Medi-Cal criteria and should be arranged through the Adult System of Care:
    - Augmented Board and Care Facilities (Non-augmented board and care facilities do NOT qualify for administrative day reimbursement.)
    - Cedar House—The TAPP Program
    - Skilled Nursing Facilities With a Psychiatric Component
    - Institutes for Mental Diseases (IMDs)
    - State Hospitals
4. For children, the following types of non-acute treatment facility placements meet Medi-Cal criteria and should be arranged through the Children's System of Care:
    - Shandin Hills Adolescent Center
    - RCL 9 Through 14 Facilities
    - Licensed augmented children's group homes (These are residential care facilities which have contracts with the Department of Behavioral Health to provide specialized, enhanced services to targeted populations.)

5. The hospital must document contacts with a minimum of five appropriate, non-acute treatment facilities per week. If there are fewer than five appropriate, non-acute treatment facilities available as placement options, the Point of Authorization may waive the requirement of five contacts per week. However, in no case shall there be fewer than one contact per week.

6. The documented contact with potential placements must include the following information:

   - Status of the placement option;
   - Date of the contact;
   - Name and title of the person contacted;
   - Signature and title of the person making the contact.

B. Authorization Procedures for Outpatient Specialty Mental Health Services

The "Outpatient Point of Authorization" is the function within the MHP which receives provider communications 24 hours per day, seven days per week, regarding requests for MHP payment authorization for outpatient specialty mental health services. When payment authorization is required, the authorization is approved or denied only by licensed, waivered, or registered mental health professionals of the MHP.

For standard authorization decisions, the MHP provides notice as expeditiously as the beneficiary's health condition requires, and within 14 calendar days following receipt of the request for service or, when applicable, within 14 calendar days of an extension. For expedited authorization decisions, the MHP provides notice as expeditiously as the beneficiary's health condition requires and within three working days following receipt of the request for service or, when applicable, within 14 calendar days of an extension.

The mailing address for the Outpatient Point of Authorization is:

San Bernardino County Department of Behavioral Health
ACCESS Unit
700 East Gilbert Street
San Bernardino, CA 92415

The Outpatient Point of Authorization's telephone number is:

Toll Free: (888) 743-1478
TDD: (888) 743-1481

The Outpatient Point of Authorization's FAX number is:

General: (909) 386-0770
For Authorizations Only: (909) 386-0775

1. MHP beneficiaries who wish to receive outpatient specialty mental health services may arrange to do so by contacting one of the following:

   - The ACCESS Unit (Outpatient Point of Authorization)
   - Any MHP outpatient clinic or contract agency

- Any credentialed fee-for-service provider of the San Bernardino County MHP

2. The following specialty mental health services are provided through the MHP's fee-for-service provider network:

   - Psychiatric Diagnostic Interview
   - Pharmacologic Management
   - Individual Psychotherapy
   - Group Psychotherapy
   - Case Conference
   - Acute Hospital Inpatient Initial Care
   - Acute Hospital Inpatient Subsequent Care
   - Nursing Facility Assessment
   - Nursing Facility Subsequent Care

   All services except for pharmacologic management (which is provided by psychiatrists only) are provided by psychiatrists, psychologists, licensed clinical social workers, or marriage and family therapists.

3. Each fee-for-service provider is permitted to provide two initial assessment sessions without preauthorization for a Medi-Cal beneficiary. All services after these two initial visits must be preauthorized by the ACCESS Unit.

4. DBH outpatient clinics and contract agencies are authorized to provide outpatient services according to the System of Periods of Allowable Treatment (SPAT). Services not specifically authorized under SPAT should be requested either through the clinic supervisor or through the ACCESS Unit.

5. Requests for Therapeutic Behavioral Services (TBS) are handled by the Department of Behavioral Health's Centralized Children's Intensive Case Management System (CCICMS), and are submitted to the ACCESS Unit.

PLANNED ADMISSION TO NON-CONTRACT HOSPITALS

For planned admissions to non-contract hospitals, the following should be submitted to the MHP's Medical Director or designee:

- A written request for MHP payment authorization;
- Supporting documentation indicating that the beneficiary meets medical necessity criteria for reimbursement of psychiatric inpatient hospital services; and
- A statement describing the need for the planned admission.

COORDINATION, OUTREACH, AND INTEGRATION WITH PHYSICAL HEALTHCARE PROVIDERS

A. Procedures for Screening, Referral and Coordination with Other Necessary Services

1. For Psychiatric Inpatient Hospital Services

a. Interagency Agreements and Collaborative Efforts

The MHP has a number of interagency agreements and collaborative efforts in place which serve to facilitate the screening, referral and coordination processes. These agreements and efforts are summarized below.

Children's Network

Department of Behavioral Health, Human Services System, County Supervisors, Juvenile Court Judges, Education, Public Health, Department of Children's Services, Probation, County Library, Head Start, District Attorney, Public Defender, and other child-serving agencies.

Children's System of Care Memorandum of Understanding

Department of Behavioral Health, Human Services System, Public Health, Department of Children's Services, Probation, Children's Fund, Superintendent of County Schools, and Children's Network.

Department of Children's Services

Enriched Youth Homes, Family Preservation, SB 163 Wraparound, and Interagency Placement Council.

Education

Special Education/Local Plan Area (AB 3632/2726) and Early Mental Health Initiative (Primary Intervention Program).

Healthy Start Programs

School Based Service Centers (located throughout the County) and Adult Education.

Probation

Juvenile Justice Outpatient Program (Juvenile Hall), Youth Justice Centers (full-day programs for youth on probation and living at home).

Interagency Placement Council

A screening committee for children's out-of-home placements comprised of representatives from the Department of Children's Services, Probation, Education and Regional Center.

Mental Health/Department of Children's Services/Sheriff/ Public Health

Child abuse cases.

Inland Counties Regional Center

Contract for 0.5 FTE Inland Regional Center case management–Children's System of Care.

Southern Counties Mental Health Directors Memorandum of Understanding

Concerning adult consumers' placement/transfer issues.

Public Health

Perinatal programs.

State Department of Rehabilitation

Cooperative agreements and case services agreements.

Regional Multidisciplinary Family Preservation Councils

Children.

City of Redlands

Supported housing.

b. Collaborative Partnerships

Collaborative partnerships exist with all of the agencies listed above in "a," and:

- Superior Courts
- Housing Coalition
- Sheriff's Department (Forensic Services)
- Department of Aging and Adult Services
- Multidisciplinary Task Force (Regional Task Forces or
- Adult Services)
- Suicide Intervention Training Programs
- Children's Program

c. Screening Process for Other Services

The goal of a managed mental health care system is a seamless system of care which provides a consistent standard to afford equal access to all eligible persons with similar needs. In order to assure this access for individuals who are hospitalized in psychiatric hospitals, the MHP provides case management services and works closely with hospitals to provide discharge consultation as well as linkage to the Adult and Children's System of Care. The screening process is as follows:

- A San Bernardino County Medi-Cal eligible consumer is admitted into a contract/non-contract psychiatric inpatient hospital.

- All fee-for-service hospitals are required by Title 9 of the *California Code of Regulations* as modified by the Code of Federal Regulations and, if applicable, by contract, to submit a 24-Hour Notification to the MHP Point of Authorization within 10 days of admission.
- The Quality Management Division notifies appropriate Department of Behavioral Health hospital case management staff of the admission.
- The Department of Behavioral Health Case Management Services provide placement, linkage, transportation, discharge consultation, information, and referral, with the goal of assisting the beneficiary and the hospital in planning for the return of the beneficiary to the community or in locating appropriate placement.
- If a consumer has been identified as a high user of inpatient services, the Department of Behavioral Health Case Management Services staff evaluate impediments to maintaining community tenure, and work to reduce the likelihood of readmission. Staff also work to develop a realistic treatment and aftercare plan with hospitals and outpatient services, and to provide clinical and service delivery information as appropriate to coordinate the care of San Bernardino beneficiaries.

2. For Outpatient Specialty Mental Health Services

The MHP is committed to the process of screening, referral and coordination with other necessary services, including, but not limited to, substance abuse treatment, education, healthcare, housing and vocational rehabilitation.

a. The processes of screening, referral and coordination of mental health with other necessary services are performed by the primary provider from which or whom a beneficiary is receiving services: a DBH outpatient clinic, a contract agency, or a fee-for-service provider.

b. Agencies with which DBH has memoranda of understanding and to which staff may refer beneficiaries include Inland Regional Center, San Bernardino County Transitional Assistance Department, San Bernardino County Juvenile Probation Department, County Department of Public Health, Inland Empire Health Plan, Molina Health Plan, San Bernardino County Unified School District, the Department of Vocational Rehabilitation, the DBH Alcohol and Drug Services Division, DBH Housing Services, and DBH Employment Services Programs.

c. The Interagency Placement Council (IPC) serves as a placement, evaluation and service planning group for the County's most seriously emotionally disturbed minors. The IPC is chaired by a representative from the MHP, and meets regularly. Member agencies include the Departments of Transitional Assistance, Children's Services, Probation, local schools, SELPAs, and the Inland Regional Center. Other child-serving agencies may attend IPC meetings and request interagency consultation. The IPC works collaboratively to identify, screen, and determine referrals for mental health placement from within the network of child-serving agencies. This group authorizes access to the most intensive levels of specialty mental health services and to specialized residential treatment.

d. Access for Special Populations

- Access for special beneficiary populations who meet criteria for specialty mental health services is arranged by the initial screening site: ACCESS Unit, DBH clinic, contract agency, or fee-for-service provider office. The MHP continues to have a range of providers with special language and cultural competencies available to assist beneficiaries (including American Sign Language). In those cases where MHP staff is not available with a particular language competence, arrangements are made to have a qualified interpreter present.
- Outreach to elderly populations is provided through the AGEWISE Program. Services are provided using peer counseling provided by trained senior citizen volunteers. Consultation to agencies working with the elderly is also available through AGEWISE. Older adults in need of mental health services are also identified through local Senior Outreach Teams.
- The MHP also maintains an AB 2034 grant which enables it to provide outreach services to the homeless mentally disabled through contract agencies. This population also accesses services through the MHP's contract hospitals and the MHP's Hospital Aftercare Services Team.

- Access for children occurs through DBH outpatient clinics, contract agencies, the fee-for-service provider network, and the Administrative Services Organization (Value Options) for those children who are in out-of-County placements. Additionally, children are referred from contract hospitals to the MHP's Home and Hospital Team, and to Project Affirm, which offers specialized case management services to children who have experienced one psychotic episode resulting in hospitalization. Severely emotionally disturbed children who are at risk of being placed in high levels of residential care are referred through the County's IPC; children receiving services from multiple County departments may be referred to a Regional Children's System of Care Team by the Family Preservation Council in the region in which they reside. Children and youth referred by these special teams have a more intensive and inclusive assessment process utilizing the system of care approach. In addition, the MHP has implemented a children's crisis response team.
- The MHP has developed programs and services for other special populations, including two vocational rehabilitation programs in the County in conjunction with the local Department of Vocational Rehabilitation. These programs are available to beneficiaries in need of supported employment services. DBH staff is co-located with Jobs and Employment Services Department offices to facilitate employment for the mentally ill clients and to address barriers to employment. Any beneficiary with dual diagnosis issues is referred to the MHP's Alcohol and Drug Services Division for assessment and possible treatment. The MHP refers beneficiaries in need of housing to the DBH Housing Program to access currently available services.
- The MHP has, and will continue to employ, active outreach strategies to locate services where clients (i.e., children, seniors) of various racial, ethnic and cultural groups will be most likely to access them. Through these outreach strategies (e.g., AGEWISE Program, Emmerton Project, Cultural Competency Unit, Native American Health Centers), the MHP continues to prioritize treatment of these beneficiary subgroups. The MHP has and continues to advertise the availability of specialty mental health services throughout the County.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for those under age 21 in need of specialty mental health services are already a part of the MHP's treatment structure. Services are provided at DBH and contract clinics, as well as through the fee-for-service provider network. In addition, the MHP has developed formal protocols with the Department of Children's Services which facilitate assessment, treatment and referral for at-risk minors in foster care.
- The MHP provides 24-hour access to services for youth and families through the ACCESS Unit. All beneficiaries under age 21 or their guardians contacting the MHP are screened and referred for services applying the EPSDT medical necessity criteria. In addition, interagency and school-based referrals continue to be received through MHP community clinics and the Children's Residential System of Care (CRSOC). Linkages continue to be developed with child-serving agencies to facilitate access for all Medi-Cal beneficiaries under the age of 21, especially for beneficiaries with special cultural and linguistic needs.
- Local MHP community clinics provide a full array of outpatient services for children and families throughout the County. The CRSOC maintains its broad spectrum of Countywide children's services, including Therapeutic Behavioral Services (TBS), the Home and Hospital Intervention Program (HHIP), assistance with interagency out-of-home placement, placement contracts with RCL 12 and 14 group homes, the MHRC level of placement, case management, and intensive outpatient services.

e. Urgent Care and Beneficiaries Who Require Specialty Mental Health Services While Outside the County

- The MHP's ACCESS Unit is available to all beneficiaries and providers 24-hours a day, seven days per week, via the toll-free number: (888) 743-1478.
- The ACCESS Unit is available to assist all San Bernardino County Medi-Cal beneficiaries who present with urgent conditions. Staff assess the beneficiaries' mental health, cultural and linguistic needs, provide crisis intervention via telephone as needed, and direct beneficiaries to appropriate additional sources of assistance (e.g., DBH clinic or contract agencies, Arrowhead Regional Medical Center (ARMC), other emergency rooms). ACCESS Unit staff are also available to respond to questions from fee-for-service providers regarding beneficiaries who are in urgent need. Network providers are informed, during provider training, that beneficiaries who present with urgent conditions should be offered services, regardless of whether it is possible to obtain advance authorization.

- For San Bernardino County beneficiaries who reside outside of the County (e.g., children in foster placements, adults in residential placements, individuals who have recently moved and not yet changed their Medi-Cal to the new county of residence), the following procedures should be followed:

  (1) **Adults with San Bernardino Medi-Cal Residing Outside San Bernardino County.** Any adult (who is not on conservatorship) who has moved to another county and has indicated a reasoned intent to reside in that county should initiate a change of Medi-Cal status. If a need for specialty mental health services should arise while the Medi-Cal status is being changed, or if the beneficiary's out-of-San-Bernardino-County status is only temporary, the beneficiary should contact the ACCESS Unit. The beneficiary will be screened to determine the nature of his/her specialty mental health needs, and will then be referred to a San Bernardino MHP provider in his/her area. In the event that there is no MHP provider in the area, the MHP will contact the local MHP and either arrange for the beneficiary to be treated by the out-of-County MHP, or solicit a list of credentialed providers from the out-of-County MHP for referral. Should this process prove unsuccessful, the MHP will ask the out-of-County MHP for a short list of recommended licensed community providers nearest the consumer.

  (2) **Minors with San Bernardino County Medi-Cal Residing Outside San Bernardino County.** Any minor with San Bernardino Medi-Cal who has moved with his/her biological parent(s) or guardian to another county and who is NOT in placement, should obtain specialty mental health services by having his/her parent/guardian follow the procedures outlined above for adults residing outside San Bernardino County. Minors with full-scope Medi-Cal residing outside San Bernardino County in group home, foster home, adoptive or kinship placement who meet medical necessity criteria should arrange for specialty mental health services through the ASO at (800) 236-0756.

- All beneficiaries who have Medi-Cal from a county other than San Bernardino County and who present with urgent conditions that cannot be ameliorated by telephone, or who are unable to make face-to-face contact with a home county MHP provider, are directed to the closest 24-hour-a-day emergency evaluation and treatment site. The San Bernardino County MHP contacts the home County MHP, by way of its toll-free number, to obtain assistance in referring the beneficiary for follow-up services. The San Bernardino County MHP queries the home MHP to determine whether it has a fee-for-service provider in San Bernardino County to whom the beneficiary might be referred. If the home county does not have any providers within San Bernardino County, the home county is asked to provide authorization for its beneficiary to be seen at a DBH clinic. Once the San Bernardino County ACCESS Unit has received the home county's authorization, it FAXes a copy of this authorization to the appropriate DBH clinic. In addition, the ACCESS Unit notifies the beneficiary that authorization has been received from his/her home county.

  NOTE: Emergency, crisis and urgent services are to be rendered to all beneficiaries without preauthorization. Providers are to contact the ACCESS Unit no later than the first business day following the rendering of these services for information regarding MHP billing procedures.

B. **Outreach Efforts Designed to Provide Information Regarding Access to Beneficiaries and Providers**

The MHP has distributed copies of its *Consumer Guide* and other beneficiary protection materials in both English and Spanish to all of the psychiatric inpatient hospitals under contract with it, to all of the DBH and contract clinics, and to all of the fee-for-service providers. All service sites have been informed that beneficiaries must be given a complete set of informational materials (*Consumer Guide*, Notice of Privacy Practices, Advance Directive Brochure, and a list of providers) upon request or upon first accessing services. The MHP also provides each beneficiary written notice of any significant changes in the information specified in Sections 438.10(f)(6) and (g) of Title 42 of the *Code of Federal Regulations* at least 30 days before the intended effective date of the change. In the case of providers, a "significant change" is defined as a 25% change in providers. In addition, all service sites have been informed of the beneficiary protection materials and other items which must be available in the waiting room (grievance forms, envelopes addressed to the ACCESS Unit, appeal forms, form for requesting a change of provider). Written materials are also available in alternative formats (e.g., large print or audio tape) for those who are visually limited.

In addition, all contract hospitals have been informed via written notification and training sessions that all Medi-Cal beneficiaries under 21 years of age admitted with an emergency psychiatric condition must be given notices regarding EPSDT and TBS at the time of admission. In addition, the Medi-Cal beneficiary's representative must also be given a copy of these notices at the time of admission.

C. Procedures for Providing Clinical Consultation and Training to Beneficiaries' Primary Care Physicians and Other Physical Healthcare Providers

The MHP plan and the two physical healthcare plans (Inland Empire Health Plan (IEHP) and Molina) have developed procedures which facilitate the coordination of care between physical and behavioral healthcare providers. In addition to having quarterly planning meetings with IEHP and Molina, the MHP conducts periodic trainings for IEHP and Molina primary care physicians on diagnosis and psychopharmacological management. MHP psychiatrists are available to provide clinical consultation to IEHP and Molina PCPs. In addition, IEHP also conducts periodic trainings which are attended by their PCPs as well as psychiatrists from the MHP. One of the benefits of this high level of care coordination is that many patients with uncomplicated psychiatric problems are able to receive treatment from the PCPs with whom they have established relationships and with whom they feel most comfortable.

PROBLEM RESOLUTION PROCESSES

A. Beneficiary Problem Resolution Processes

1. Grievance Procedure

- Beneficiaries who are receiving specialty mental health services through the MHP are entitled to file a grievance—either orally or in writing—about the services they have received. The grievance may be filed with the beneficiary's care provider, with the ACCESS Unit, or with the Patients' Rights Office.
- Beneficiaries have the right to authorize another person to act on their behalf during a grievance or appeal procedure. Beneficiaries may also identify a staff person or other individual to assist them with the grievance or appeal process (See "Action Appeal Procedure" section on the next page.).

  Beneficiaries also have the right to select a provider as their representative during the appeal process.
- Staff should make every effort to resolve grievances at the proper level. Resolution may be achieved through disclosures between the beneficiary and the therapist/case manager, clinic supervisor, program manager or the ACCESS Unit. The Patient's Rights Office is also available as a resource.
- If grievances cannot be resolved at the provider level, a grievance form may be completed by the consumer and sent to the ACCESS Unit or the consumer may call the ACCESS Unit to attempt to resolve the issue. After receiving a grievance, the ACCESS Unit sends a letter to the consumer acknowledging the grievance has been received, and outlining the steps in the appeal and State Fair Hearing processes. The ACCESS Unit has 60 days in which to resolve the issue. After resolution is achieved, the ACCESS Unit sends a letter to the beneficiary describing what has occurred. A 14-day extension may be granted if this is in the best interest of the consumer. Once a grievance as been closed, it is forwarded to the Continuous Quality Improvement Committee (CQIC).
- A grievance log is maintained by the ACCESS Unit in order to monitor the progress and resolution of each grievance.
- Contacts for Filing a grievance:

ACCESS Unit
San Bernardino County Mental Health Plan
700 East Gilbert Street
San Bernardino, CA 92415-0920
(888) 743-1478
FAX – (909) 386-0770

Patients' Rights Office
San Bernardino County Department of Behavioral Health
700 East Gilbert Street
San Bernardino, CA 92415-0920
(888) 743-1478
FAX – (909) 386-0770

2. Action Appeal Procedure

- The following are procedures to be used when the consumer's dissatisfaction is the result of an Action by the MHP. An Action is defined as:
    - A denial of or reduction in an authorization request, including a change in the type or level of service;
    - Reduction, suspension, or termination of a previous service authorization;
    - Denial, in whole or in part, of payment for a service;
    - Failure to provide services in a timely manner, as determined by the MHP; or
    - Failure to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.
- A consumer may complete an Action Appeal Form, which is to be forwarded to the ACCESS Unit, or may initiate an Action Appeal orally with the ACCESS Unit. Verbal appeals must be followed up in writing by the consumer within 45 calendar days of the date on which the verbal Appeal was communicated.
- The beneficiary and his or her representative have the right–before and during the appeals process–to examine the beneficiary's case file, including medical records, and any other documents and records considered during the appeals process.
- A written acknowledgement of the Action Appeal is sent to the consumer. This acknowledgement also contains information on how the consumer may pursue subsequent requests for additional review. A written response to the Appeal is made within 45 calendar days from the date of receipt of the form and is mailed to the beneficiary. A 14-day extension may be granted if it is determined to be in the best interests of the consumer.
- An expedited review process for Appeals occurs if the MHP determines that the time usually taken for a standard resolution would seriously jeopardize the beneficiary's life, health, or ability to function. Under the expedited process, the MHP notifies the parties

no later than three working days after the MHP has received the Appeal.

- An Appeal Log is maintained by the ACCESS Unit to monitor the progress and resolution of Appeals.
- Following resolution, Appeals are forwarded to the Continuous Quality Improvement Committee (CQIC).

3. State Fair Hearing Procedure

- Consumers who have received a Notice of Action may request a State Fair Hearing at any time before, during, or after the appeal process has begun. The beneficiary has 90 days from the date on which the Notice of Action was postmarked or 90 days from the day on which the Notice of Action was personally given to the beneficiary. The beneficiary may also be eligible to continue receiving services pending the outcome of the State Fair Hearing **if the request for a State Fair Hearing is made within 10 days of the date on which the Notice of Action was postmarked or was personally handed to the beneficiary or before the effective date of the change, whichever is later.**
- The "Fair Hearing Tracking Log" is maintained by the ACCESS Unit to monitor the progress and resolution of each request for a State Fair Hearing.
- Information regarding State Fair Hearings is forwarded to the Continuous Quality Improvement Committee (CQIC).
- The ACCESS Unit is responsible for coordination with the State Department of Social Services, State Department of Mental Health, providers, and beneficiaries regarding the State Fair Hearing process. The ACCESS Unit also oversees compliance with the State Fair Hearing decisions.
- State Fair Hearings may be requested by calling or writing:

Public Inquiry and Response
744 – "P" Street, M.S. 16-23
Sacramento, CA 95814
(800) 952-5253
TDD – (800) 952-8349

-B. Provider Problem Resolution Processes

The MHP's provider problem resolution process includes a verbal or complaint process, and a written or grievance process. Providers are encouraged to contact the MHP at the telephone numbers given below to discuss concerns or problems they may be experiencing so that these can be resolved on as simple and informal a basis as possible.

Providers may appeal a denied, terminated or reduced request for MHP payment authorization for psychiatric inpatient hospital services or for outpatient services. The procedures and timelines for the provider appeals process are outlined below:

- The provider must submit a written appeal to the MHP within 90 calendar days of the date of receipt of the MHP's non-approval of payment or within 90 days of the MHP's failure to act on the provider's request.
- The MHP has 60 calendar days from its receipt of the written appeal to inform the provider in writing of the decision. If the appeal is not granted in full, the provider is notified of any right to submit an appeal to the State Department of Mental Health.
- If the MHP does not respond within 60 calendar days to the provider's appeal, the appeal is considered denied.
- The provider has 30 calendar days from receipt of the MHP's decision to approve the provider's payment authorization request to submit a revised request. In the case of psychiatric inpatient hospital services, the MHP has 14 calendar days from the date of receipt of the provider's revised request to submit the treatment authorization request to the fiscal intermediary for processing.
- When an appeal concerning the denial or modification of a payment authorization request for psychiatric inpatient hospital services **in an emergency situation** is denied, in full or in part, by the MHP on the basis that the provider did not comply with required timelines, or did not supply documentation which established medical necessity, the provider may appeal to the State Department of Mental Health.
- Providers' appeals of an MHP's denial or modification of a payment authorization must be submitted in writing within 30 calendars day of the date of the MHP's written decision of denial. The provider may appeal to the State Department of Mental Health within 30 calendar days after 60 calendar days from the date of the original submission of the appeal to the MHP if the MHP fails to respond.
- The State Department of Mental Health notifies the MHP and the provider of its receipt of a request for an appeal within seven calendar days.
- The MHP then has 21 days in which to submit requested documentation to the State Department of Mental Health.
- The State Department of Mental Health then has 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation, whichever is earlier, to notify the provider and the MHP in writing of its decision.

- Finally, the provider has 30 calendar days from receipt of the State Department of Mental Health decision in which to submit a revised request for MHP payment authorization, if applicable. The MHP then has 14 calendar days from receipt of the provider's revised request to approve the MHP payment authorization or submit documentation to the Medi-Cal fiscal intermediary required to process the MHP payment authorization.
- The MHP contact information for **provider appeals related to psychiatric inpatient hospital services:**

Inpatient Authorization Unit
San Bernardino County Mental Health Plan
850 East Foothill Boulevard
Rialto, CA 92376
Phone – (909) 421-9253
FAX – (909) 873-4441

- The MHP contact information for **provider appeals related to outpatient services:**

ACCESS Unit
San Bernardino County Mental Health Plan
700 East Gilbert Street
San Bernardino, CA 92415-0920
Phone - (888) 743-1478
FAX – (909) 386-0770

THE PROVIDER SELECTION PROCESS

A. Hospital Providers

The San Bernardino County MHP has, in accordance with Section 1810.430(a) of Title 9 of the *California Code of Regulations,* offered a contract to all hospitals which are either (1) Disproportionate Share Hospitals, and provide services to a disproportionate share of low-income individuals as determined annually by the Department of Health Services, or (2) Traditional hospitals which account for five (5) percent or $20,000, whichever is more, of the total psychiatric inpatient hospital payments for the MHP's beneficiaries. Contracts are now in place with all of the hospitals that were offered contracts. , One out-of-County facility declined.

B. Individual Providers

The following steps describe the provider selection process for individual fee-for-service providers:

- Clinicians who express an interest in becoming a fee-for-service provider with the MHP are presented with a credentialing application which must be completed by the candidate.
- The prospective provider must submit a copy of his/her license and malpractice insurance verification.
- The MHP Credentialing Committee reviews the National Practitioners Data Bank information system to obtain information regarding the prospective provider.
- The Credentialing Committee contacts the appropriate California licensing board to verify current licensure and good standing.
- The above data are collected, packaged and sent to a credentialing company for review and recommendations. If the credentialing company confirms good standing status for the applicant, the Committee approves the applicant to be a member of the MHP's fee-for-service provider network.
- Once approved, the provider signs a San Bernardino County MHP ***Provider Service Agreement.***
- Each new provider attends a provider training session at which he/she receives a copy of the ***Provider Manual.***
- All providers are maintained and renewed on the basis of their compliance with Title 9 regulations.
- Providers who are prohibited from federal participation according to the list maintained by the Office of the Inspector General, Department of Health and Human Services, are not accepted or recertified as fee-for-service providers of the MHP.

DESCRIPTION OF CULTURALLY COMPETENT AND AGE APPROPRIATE SERVICES FOR BENEFICIARIES

The San Bernardino County MHP has a Cultural Competency Implementation Plan which has been approved by the State Department of Mental Health.

A. Synopsis

The State of California continues to experience population growth in many ethnic groups. According to the Surgeon General's Report, Mental Health: Culture, Race and Ethnicity 2001, and the Little Hoover Commission 2000, "Minorities receive treatment at a rate that is even lower than that of the general population. Ethnic minority populations appear to bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity."

Against this backdrop, the San Bernardino County MHP as experienced a dramatic increase in service demands by various ethnic populations. It is the intent of the MHP's Cultural Competency Plan to address access barriers, poor penetration rates and to develop a system of care that incorporates appropriate cultural and linguistic services by reviewing, evaluating and modifying the current system. The MHP's efforts will include:

- Aggressive recruitment and retention of bilingual and bicultural staff (modified by budgetary constraints)
- Training protocols and curricula to address needs of ethnic groups
- Research
- Community-based outreach/engagement strategies to increase delivery of services to underserved populations in order to increase penetration rates (volunteers, grassroots faith-based organizations should be included)
- Community forums for input in the development of appropriate cultural and linguistic services
- Maintenance of the Cultural Competency Committee to foster and implement State requirements on cultural competency
- Identification and participation in interagency committees in order to foster cultural competency

B. Background

California's population is among the most culturally diverse in the United States, and San Bernardino County's population reflects similar diversity. Age distribution in the San Bernardino County population reflects California's population in most areas, the exception being the percentage of children in the population. The percentage of individuals under 18 years of age for the State is 27.3%. San Bernardino County, however, has 32.4% (Census 2002). The largest age group was denoted as the 24 to 54 age group at 42%, followed by the 5 to 17 segment at 24%. From 1990 to 2000 there has been a 79%, 48%, and 36% increase in the Hispanic, Asian/Pacific Islander (non-Hispanic), and African American (non-Hispanic) populations, respectively. During the same period there was a 13% decrease in the White (non-Hispanic) population. There was a 21% increase in the overall population. Much of the County's population growth since the 1970s has been linked with the economies of Los Angeles and Orange Counties, as evidenced by the concentration of population increases in areas adjacent to or within commuting distance of these jurisdictions. Rapidly escalating housing prices in Orange and Los Angeles Counties, combined with affordable housing in San Bernardino, have been major contributors to the population influx along with the marked immigration increase from Mexico, Latin America and the Pacific Rim.

The largest industries throughout the County are education, health and social services—and this finding is consistent in all regions. The Medi-Cal caseload has surpassed 100,000 for the first time. The median household income is $41,834 with a bimodal distribution of approximately $38,000 in roughly 75% of the County regions, and $52,000 in the West Valley Region, which more closely borders Orange and Los Angeles County metropolitan areas. Thus, 37.1% of the households are in the middle-income level, and 21% are in the high-income level, earning above $75,000 per year.

According to the "Mapping a System of Children's Group Homes in San Bernardino County" report, the County is the largest one in the State. It is not surprising that there are 90 group homes in the County receiving referrals from Probation, Children's Services, Behavioral Health and agencies from other counties such as Los Angeles, Riverside, and Orange. The MHP has placed approximately 40 youth per year since 1996. The MHP's DBH signed a memorandum of understanding with the Department of Children's Services (DCS) to evaluate children in foster home placement for mental health needs. DCS's Year-To-Date Report states that, as of January 14, 2004, DCS was providing ongoing services to 6001 cases.

Two demographic trends have recently gained much attention in the United States: Rapid growth in the Hispanic population, and a large projected increase in the percentage of senior citizens, both of which are evident in the County.

Homelessness is also on the rise nationally and Statewide. In the County of San Bernardino, homelessness ranges between 0.8% and 1.3% of the population, or up to 23,549 unduplicated cases.

The threshold language in San Bernardino County is Spanish. The MHP employs individuals who translate and interpret, and because of their bilingual ability receive additional compensation. San Bernardino has a higher density of Spanish speakers than California and the United States. One result is that there is a shortage of Spanish language services available for monolingual Spanish beneficiaries.

In January, 2003, there were 338,067 Medi-Cal beneficiaries, representing 20% of the total County populations. The Latino/Hispanic beneficiaries represent the largest component in the increase in Medi-Cal beneficiaries for the last four years. This group is clearly the fastest growing.

C. Mental Health Services

When considering the Hispanic, African American, White and Asian population groups who are significantly represented, it should be noted that these groups are widely dispersed throughout the County. In addition, with regard to DSM-IV diagnosis, there are patterns of central tendency for each group that range from schizophrenia, mood/anxiety disorders, adjustment disorders, and childhood/adolescent disorders with covariance dependent upon region and group identity.

The County is divided into four regions for MHP planning purposes, each with roughly a half million residents: West Valley, Central Valley, East Valley and Desert/Mountain regions. Each region is composed of county operated clinics, contract providers, and specialized programs, and each has a Resource Service Center. Each Resource Service Center provides services for adults, older adults, children and their families. Services include, but are not limited to, medication support, individual therapy, group therapy, case management, intensive case management, crisis intervention, walk-in services, and homeless programs. School-based outpatient and CalWORKs services are also located in all four regions. In addition, each region has a Recovery/Club House run by clients. In an attempt to have a seamless system of care, the MHP has integrated Drug and Alcohol Services into all of the regions. Specialized programs are Children's System of Care, Homeless Program, Hospital Diversion, Forensics, and Intensive Day Treatment Programs. These services are available to all beneficiaries.

During calendar 2002, there were 20,510 Medi-Cal beneficiaries receiving specialty mental health services in San Bernardino County. Forty-eight percent (48%) of those beneficiaries were Caucasian, 25.8% were Latino/Hispanic, and 29.9% were African-American. Females outnumbered males 54.0% to 45.9%. Mood disorder was the primary diagnostic category (44.9%) compared to 20.5% for schizophrenia/psychotic disorder. The primary language was English for 89.5% of the group.

Caucasians utilized outpatient services more than other groups (48.4%), compared to 25.8% for Latino/Hispanics and 19.9% for African-Americans.

D. Summary

The MHP's Cultural Competency Plan has a detailed analysis of the following: penetration dynamics, language challenges, diagnostic parameters, outreach strategies, education needs, resource availability and constraints, population trends, quality improvement strategies, and budgetary considerations. All of these issues serve as a stage for continued development and implementation of cultural competence proficiency, which is a work in progress.

Providers are challenged to plan, develop and implement an inclusive, accessible and relevant system of care for beneficiaries of diverse populations, which provide culturally and linguistically appropriate services. In addition, there must be an awareness of trends such as the decrease in the percentage of the Caucasian population with high utilization, while there are significant increases in the Hispanic and African-American populations utilizing services.

It should be noted that an age appropriate and culturally competent system of care emphasizes the importance of age, culture, acculturation, language, gender/gender identity and cultural values in the service delivery system. Age appropriate services and cultural competence are integrated into all aspects of the MHP implementation and evaluation process. The MHP's capacity to provide culturally competent services relies on the following:

- Multilingual and multicultural staff (recruitment/retention)
- Responsive community outreach and education
- Staff development/training in cultural diversity, geriatric and children's service
- Development, implementation, and utilization of cultural/age competency assessments for providers with annual review
- Collection and analysis of patient data, including penetration rates for diverse populations
- Culturally appropriate program design
- Identification of, and outreach to, resources currently used by both populations
- Availability of grievance procedures, medications, and treatment information in the consumer's primary language
- Development and evaluation of culturally and age-appropriate relevant outcome measures

THE QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT PROGRAMS

A. Quality Improvement Program

The San Bernardino County MHP Quality Improvement Program is accountable to the Director of Mental Health.

1. **Committees:** The Quality Management Program is the umbrella division which encompasses the Quality Improvement Program (QIP) and Utilization Management Program (UMP). The QIP is overseen by the Quality Management Committee, which meets monthly and includes three subcommittees: Continuous Quality Improvement, Clinical Records, and Medication Monitoring. The Quality Management Committee is chaired by the Director of Medical Services (a psychiatrist) within the DBH, and, therefore, the QIP functions under a licensed mental health staff person who is involved in the QIP implementation.

2. **Committee Composition:** The Quality Management Committee is composed of a multidisciplinary team, including psychiatrists, psychologists, psychiatric social workers, marriage and family therapists, and nurses. Moreover, it also includes family and consumer representatives. Both the Continuous Quality Improvement and the Clinical Records Committees consist of multidisciplinary teams of licensed mental health professionals, including psychiatrists, psychologists, psychiatric social workers, marriage and family therapists, and nurses. The Medication Monitoring Committee is composed of psychiatrists and nurses.

3. **Committee Functioning and Meeting Frequency:** The Quality Management Committee functions as the coordinator of the Quality Improvement subcommittees. It implements the QIP and oversees the activities of the three subcommittees. It also recommends policy and insures follow-up of the quality improvement process. The Medication Monitoring Subcommittee is responsible for examining all medication issues, both inpatient and outpatient. The Continuous Quality Improvement Subcommittee reviews and monitors possible quality of care issues and makes recommendations to improve mental health services provided to consumers. The Clinical Records Committee insures the standardization of clinical records and documentation procedures.

4. The committees may create workgroups or subcommittees as necessary. These special work groups will be task-specific and include staff, beneficiaries and providers, as appropriate. All of the committees meet on a monthly basis, but may meet more frequently, or as needed, to complete actions. Dated and signed minutes reflect all quality improvement committee decisions and actions.

5. Practitioner, Provider, Consumer and Family Member Involvement

a. The MHP works closely with the San Bernardino County Mental Health Commission, which is composed of diverse providers, consumers and family members in the development of the implementation plan and quality improvement process. Moreover, input from this group is included in the development of the outcome measures for the quality improvement system. Consumer input is included in the development of outcome measures for the quality improvement system. The Mental Health Commission is active in the planning process, and has input into the quality improvement plan.

b. The MHP solicits information from diverse providers, beneficiaries and family members by means of questionnaires and satisfaction surveys (available in both English and Spanish) on a regular basis. The questionnaires include items concerning quality of care issues to determine consumer perceptions and levels of satisfaction with available services and suggestions for improvement. The MHP uses the results of these surveys to make improvements in the provision of services as appropriate so these groups have input into the continuous quality improvement processes.

6. Delegation

The MHP does not delegate any quality improvement activities to a separate entity.

7. The MHP submits annual Quality Improvement Work Plans as required.

B. Utilization Management Program

1. Authorization Process For Services Provided Through the Fee-For-Service Provider Network

a. The MHP's ACCESS Unit is responsible for preauthorizing all non-emergency outpatient specialty mental health services for San Bernardino County Medi-Cal beneficiaries who receive services through the fee-for-service provider network. Beneficiaries without currently approved network services from the MHP are required to contact the ACCESS Unit or one of the fee-for-service providers for a screening of their service needs.

b. Following the two initial assessment sessions which do not require preauthorization, the beneficiary's provider submits authorization paperwork to the ACCESS Unit for authorization of additional services. If these approved service contacts are sufficient to resolve the presenting problem, the provider closes the episode and submits the required treatment documentation along with all relevant claims information to the MHP..

c. Reauthorizations are made in a way similar to what is described above

2. Authorization Process For Services Provided Through DBH Clinics/Contract Agencies

a. Day Treatment Services: When a DBH or contract agency indicates a desire to establish day treatment services for the beneficiary, a treatment authorization request must be submitted to the ACCESS Unit. The ACCESS Unit approves, modifies, or denies the request. In the event of modification or denial, an NOA is issued.

b. Therapeutic Behavioral Service: Therapeutic Behavioral Service (TBS) is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health service which provides intensive one-to-one short-term outpatient treatment interventions for beneficiaries under the age of 21, with serious emotional problems or mental illness who are experiencing a stressful transition or life crisis, and need additional short-term specific support services. TBS is intended to prevent placement of a child/youth in a group home at RCL 12 through 14 or a locked facility for the treatment of mental health or to enable a transition from any of those levels to a lower level of residential care.

When there is a need to provide Therapeutic Behavioral Services to a consumer, the contract provider for DBH, Mental Health Services, Inc (MHS, Inc) completes a treatment authorization request and submits it to the ACCESS Unit. ACCESS then approves, modifies, or denies the request. In the event of modification or denial, ACCESS issues an NOA. Specific requirements for initial and reauthorizations are given in Exhibit "A"–Attachment 1 to the contract between the California State Department of Mental Health and the San Bernardino County Department of Behavioral Health.

c. All Other Outpatient Services: DBH outpatient clinics are authorized to provide services according to a "System of Periods of Authorized Treatment," which takes into account diagnosis and functional severity. If an outpatient clinic wishes to provide services that are not authorized by this system, a request should be made to the clinic supervisor or to the ACCESS Unit.

3. Delegation

The MHP does not delegate any UM activities to a separate entity.

POLICIES AND PROCEDURES FOR ASSURING BENEFICIARY CONFIDENTIALITY

The MHP has guidelines, standard operating policies and procedures designed to protect beneficiary confidentiality and privacy, all of which are in accordance with HIPAA requirements.

The MHP's Quality Management Division conducts audits to ensure compliance with established federal and State laws and regulations. A Code of Conduct policy has been created to educate MHP participants regarding the importance of adherence to legal and regulatory standards. A HIPAA Notice of Privacy Practices is provided to beneficiaries in an effort to inform them about their rights.